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Characteristics of effective communicative partners for veterans with Post-Traumatic Stress Disorder (PTSD)

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Characteristics of Effective Communicative Partners for Veterans with Post-traumatic Stress Disorder (PTSD)

by

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Dedication

To my mother and father, Patricia and Bruce Dunzweiler

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Abstract

This study identifies communicative and non-communicative characteristics of spouses of veterans with PTSD as discussed by the participants. Due to the exposure to traumatic events, language abilities of soldiers are often affected, commonly delaying the retrieval of memories as well as analysis and production of everyday speech. These symptoms make it difficult to perform the communication behaviors that are conducive for healthy relationships. Improved acceptance and acknowledgment of PTSD in veterans by the armed services has increased the demand for preventative and therapeutic methods being used to treat returning veterans assimilating back into society. Qualitative methodology was used in this study to obtain rich descriptions of interactions spouses have experienced. This study is intended to give professionals and family members of veterans with PTSD perspectives of communication methods used by spouses.

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Chapter 1: Introduction

Background Information

According to a Veterans Affairs Medical Center (VAMC) information pamphlet provided to families of returning veterans, 11–20% of service members are eventually diagnosed with post-traumatic stress disorder (PTSD; VA National Center for PTSD, 2009). PTSD is a condition caused by experiencing a traumatic event and can have a negative impact on communication. Specific PTSD symptoms that can effect communication include anxiety, anger, avoidance, changing attitudes, and increased arousal. This study focuses on the communication experience of wives with their husbands, veterans of the Vietnam War. The wives are communication partners, the people on the opposite end of the sender-receiver connection in conversation; therefore, they have an intimate understanding of the communication challenges experienced due to PTSD.

Purpose of the Study

The goal of this study is to learn about the communicative experience of communication partners of veterans. This may shed light on the needs of communicative partners to further develop communication strategies and implications for treatment.

Research Question

This study is designed to address the research question, what strategies are being used by communication partners of veterans who have been diagnosed with PTSD?

Chapter 2: Review of the Literature

Post-traumatic stress disorder (PTSD) is a trauma and stressor related disorder that can occur after someone goes through a traumatic event like combat, assault, or disaster. For PTSD diagnosis, a stressor criterion must be met, meaning that the person must have been exposed to an event that is considered traumatic, (e.g. rape, an explosion, or witnessing the death of someone; National Center for PTSD, 2009). Because of varying thresholds for trauma, not everyone experiences PTSD symptoms when exposed to stressors. Some individuals have little to no reactions to stressors, while others can develop a full-blown syndrome in reaction to the same stressor event (Friedman, 2014). Delayed expression of PTSD can occur, which means diagnostic criterion is not fulfilled until at least six months after the trauma. When delayed, symptoms typically surface due to a set of circumstances that bears a resemblance to the original trauma (Friedman, 2014). The limited longitudinal research available verifies that PTSD can become a chronic psychiatric disorder marked by relapses and remissions (Friedman, 2014).

Symptoms of PTSD include avoidance, negative alterations of mood and cognition, alterations in arousal and reactivity, alcohol and drug abuse, a sense of social isolation, and alienation (American Psychiatric Association, 2013). Hyperarousal, increased sensitivity, and sleep abnormalities are common due to psychophysiological changes to the sympathetic nervous system (Friedman, 2014). These symptoms are persistent and significantly impact daily life.

PTSD and Veterans

Veterans with recent deployment have significantly higher levels of PTSD symptoms (Allen, Rhoades, Stanley, & Markman, 2010). According to a study by Bjornstead (2009), over

half of soldiers from Operation Enduring Freedom (OEF) in Afghanistan, deployed between 2001–2014, and Operation Iraqi Freedom (OIF) in Iraq, deployed between 2003–2010, reported feeling distant or cut off from other people. PTSD triggers can vary in severity and complexity. Examples include holidays, situations, noises, smells, or certain types of terrains. Fear related to triggers of trauma can cause veterans to exhibit avoidance behaviors. Some veterans choose to be isolated when struggling with PTSD due to the military's culture that places a stigma on communicating mental health symptoms and asking for help (Johnson et al., 2007). Different labels have been applied to the masking and denial of PTSD symptoms, such as military mindset or post-deployment syndrome (Schneider, Haack, Owens, Herrington, & Zelek, 2009). The resulting isolation through masking or denial creates a challenging environment for developing trust with spouses and family members that want to support the veteran (Francis, 2010).

Almost half of soldiers experience hyperarousal following deployment — a symptom that can present itself as a jittery feeling, anger or irritability. Additionally, soldiers have reported that hyperarousal causes them to have trouble sleeping, concentrating, and irrational paranoia (Bjornstead, 2009). These overly alert reactions are usually constant, unlike other PTSD symptoms that are triggered by memories of the event.

With PTSD becoming one of the most commonly diagnosed and treated mental illnesses among the veteran population, accuracy of diagnosis has become a focus of research (Schneider et al., 2009). According to a population-based study published by the RAND Corporation and the Center for Military Health Policy Research in 2014, 13.8% of soldiers that served in OEF and OIF were diagnosed with PTSD (Gradus, 2014). The prevalence of PTSD symptoms was significantly greater for soldiers that served in OIF compared to those that served in OEF (Bjornestead, 2009). From 2002–2011, 1,333,627 OEF, OIF, and Operation New Dawn veterans

had left active duty and were eligible for VAMC care, and 711,986 had obtained care (Beck & Cornis-Pop, 2011). In 2011, 51% of veterans were receiving services through the VAMC for mental health issues (Beck & Cornis-Pop, 2011). PTSD symptoms are considered hidden or invisible wounds because they tend to co-occur with brain injuries, otological and vestibular problems, and pain syndrome (Beck & Cornis-Pop, 2011). This creates another complicated barrier for diagnosis and treatment.

PTSD, TBI, and Veterans

The OIF and OEF conflicts have caused increased incidence of traumatic brain injury (TBI) due to improvised explosive devices (IED), mortar attacks, and explosions from mines (Elder & Christian, 2009). According to a study by Okie (2005), 59% of veterans returning from deployment had been exposed to attack that could cause TBI. Veterans who have experienced mild traumatic brain injury have a higher chance for developing "psychiatric disorders compared the general population, including depression and PTSD" (Summerall, 2014, p.1). Traumatic experiences have been compared to pain due to the similar way they are filtered through cognitive and emotional processes before the body acknowledges them as a threat (Friedman, 2014). When a soldier experiences a blast from an IED and as a result has a mild traumatic brain injury (mTBI), the cognitive processes can become compromised (Elder & Christian, 2009). This creates a disposition to PTSD that in turn makes it difficult for the cognitively impaired brain to process PTSD symptoms.

PTSD Veterans and Their Spouses

When spouses have to learn how to manage their soldier's PTSD symptoms, it is very difficult and may present the unforeseen need for strength either to work on the PTSD-related symptoms with the veteran or to separate from the relationship (Woods, 2010). Sometimes spouses do not know about the symptoms of PTSD and how those symptoms will affect their relationship. Symptoms of PTSD are negatively related to virtually all areas of marital functioning for both husbands and wives (Allen, Rhoades, Stanley, & Markman, 2010). This was measured in a study on the relationships between recent deployment and post-traumatic stress symptoms (Allen et al., 2010). The aspects of marital functioning impacted by PTSD included confidence that the marriage can survive long term, dedication to each other and the marriage, and satisfaction with sacrifice. PTSD symptoms damaged the confidence couples had in the longevity of their relationship, but it did not have as much of a negative effect on their desire for the relationship to last.

PTSD symptomology has been found to be the reason for ending marriages in younger military couples compared to older couples that were more likely to continue working on their relationship (Woods, 2010). A majority of spousal relationships for veterans with PTSD experience clinically significant higher levels of stress as compared to those without PTSD (Schneider, et al., 2009). A study by Biddle, Elliott, Creamer, Forbes, and Devilly (2002) gave treatment-seeking veterans with PTSD and their spouses an opportunity to rate primary behavior problem areas for the veteran. Both the veterans and their spouses rated highly the categories that are associated with PTSD including anger, interpersonal problems, increased anxiety and depression, intrusive thoughts, alcohol dependency, and sleep deprivation. These problems were unpredictable and made communication a challenge for participants.

Recently deployed soldiers have access to communication modalities that were not available in past conflicts. Advancements in technology have made it possible for couples to stay in contact during deployments. A study that looked at the relationship between spousal communication and PTSD symptoms found that a greater frequency of communication among spouses during deployment predicts lower levels of PTSD symptoms (Carter, Loew, Allen, Stanley, Rhoades, & Markman, 2011). This was only found in the form of delayed communication. The "delayed forms of communication, such as letters, emails, or care packages, provide tangible objects that may be revisited repeatedly by soldiers, thus providing repeated support" (Carter et al., 2011, p. 354). Though these results may not seem to relate to veterans in past wars where communication was limited, it may explain why couples that were able to write letters to each other were not severely affected by PTSD symptoms following service.

A current evidence-based model used with active service people, Cognitive-Behavioral Conjoint Therapy (CBCT), is a disorder-specific couple therapy that is designed to "simultaneously decrease PTSD symptoms and enhance intimate relationship functioning" (Blount, Fredman, Pukay-Martin, Macdonald, & Monson, 2014, p. 1). This therapy method is used by mental health professionals and it follows the course of treatment below that directly addresses communication challenges service members and spouses experience due to PTSD:

1. Treatment rationale and psychoeducation about PTSD symptoms and relationship difficulties
2. Communication skills training and couple-level in-vivo exposure approach activities to enhance positivity and decrease avoidance (i.e., paraphrasing; recalling avoided people, places, and locations; communicating feelings and thoughts related to PTSD; and

acknowledging how avoidance interferes with ability to generate coherent descriptions of deployment)

3. Dyadic cognitive interventions for trauma-related beliefs maintaining PTSD and relationship difficulties

This flow of treatment demonstrates the utility of a "conjoint approach to treating PTSD that simultaneously targets PTSD symptoms, maladaptive cognitions held by either member of a couple, and maladaptive relationship processes, such as couple-level of avoidance of situations, places, people, and feelings that are associated with discomfort for the identified patient and can affect relationship satisfaction" (Blount, et al., 2014, p.466). Furthermore, the success in implementation of CBCT exhibits the valuable role that partners can play in helping to modify trauma-related frustration points that the patient may hold. This treatment has limited success with couples that are no longer committed to their relationship. Consequently, one of the requisites for CBCT for PTSD is an agreement that each partner will remain committed to the relationship for the duration of treatment (Blount, et al., 2014).

Few studies have compared the severity of the trauma experienced by soldiers and how their PTSD symptoms affected the spouse. According to Bjornstead (2009), severity of combat exposure directly predicts post-traumatic stress symptoms in the soldier, but not secondary symptoms in the spouse. Secondary PTSD symptoms refer to the presence of PTSD symptoms caused by at least one indirect exposure to traumatic material. This study only looked at symptoms of re-experiencing, avoidance, emotional numbness, and hyperarousal. These may not be the particular symptoms the spouse experiences. The study additionally found that the severity of post-traumatic symptoms in the soldier predicts the severity of secondary traumatic stress

symptoms in the spouse. This recognizes that spouses could be proactive in receiving counseling based on their soldier's post-traumatic symptoms.

PTSD Veterans and Speech-Language Pathologists

Medical sequalae of deployment that are unique to the OEF and OIF conflicts include TBI as well as polytrauma and PTSD (Beck & Cornis-Pop, 2011). Polytrauma is a medical term used to describe the condition of a person who has been subjected to multiple traumatic injuries, such as severe head injury in addition to PTSD. In response to polytrauma, an integrated system of health care has been developed in the United Stated to treat these cases on an individual basis. Speech-language pathologists (SLPs) play a primary role in the evaluation and management of individuals with cognitive-communication disorders, including cognition as manifested through verbal or nonverbal communication.

Communication includes listening, speaking, gesturing, reading, and writing in all domains of language: phonologic, morphologic, syntactic, semantic, and pragmatic. Cognition includes cognitive processes and systems: attention, perception, memory, organization, and executive functioning. Cognitive impairments also affect areas of function, such as behavioral self-regulation, social interaction, activities of daily living, learning and academic performance, and vocational performance. SLPs address limitations in these areas that are caused by cognitive-communication impairments. Additionally, SLPs provide education and counseling about cognitive-communication deficits to facilitate effective communication to establish supportive social networks for veterans.

SLPs treat both combat and non-combat veterans. The symptoms of TBI and PTSD are addressed sequentially or concurrently; however, the priority is to treat any reversible factors

early and aggressively. A study on the treatment of cognitive-communication disorders in the context of TBI and PTSD found the following overarching themes: recognize and embrace the complexity and ambiguity of the TBI and PTSD issues, concomitant TBI and PTSD are not unusual and may have significant overlap in symptoms, and cognitive-communication symptoms from non-TBI causes may require treatment of an underlying disorder, such as PTSD (Beck & Cornis-Pop, 2011).

Evidence-based speech-language pathology treatment options for polytrauma are basically limited to TBI treatments. Existing interventions and clinical consensus are the only options because best practice protocols have not been created yet, which are an immediate need due to the high volume of veterans experiencing traumas and being discharged to their civilian lives (Beck & Cornis-Pop, 2011). Current SLP treatments focus on improving the communication and cognition domains mentioned above as well as aiding in the use of strategies that are restorative or compensatory based on the needs of the veteran.

Communication Partners, Conversational Discourse, and Life Participation

Educating military couples on communication skills and positive bonding is impactful for intervention in protecting these couples or restoring them from the effects of PTSD (Carter et al., 2011). In addition, these strategies could serve to directly address symptoms of PTSD such as avoidance. A study that focused on the supports offered to caregivers of patients with TBI discussed that a partner's understanding of potential supports for conversational communicative behaviors appears to affect his or her aptitude to support that individual with communicative dysfunction (Bowen, Tennant, Neuman, & Chamberlin, 2001).

Hoepner (2010) found that after interviewing communication partners of TBI patients, he was able to identify effective and non-effective characteristics. Hoepner used a partner support behavior profile (PSBP) in his study to evaluate and measure partner behaviors in the scope of TBI. The profiles took into consideration partner-initiated conversation management (i.e., topic elaboration, maintenance of topics, and topic transition), and partner initiated repair strategies (i.e., reframing, redirecting, and requests for clarification). PSBPs were developed on anecdotal observations, literature on common communication problems in individuals with TBI, efficient use of time and resources, collaboration, practice, functional use, and the clinical knowledge of potentially supportive communication behaviors. This method of profiling was proficient in categorizing partner behaviors into subtypes, allowing for clear identification of effective as well as negative partner supports. Unlike other instruments available, PSBP also measured "perceived success, enjoyment, and the burden of interactants."

Similarly, this study will focus on the communicative characteristics of effective communication partners, but with veterans that have PTSD. According to the National Vietnam Veterans Readjustment Study (NVVRS), out of 3,016 Vietnam veterans, the "estimated lifetime prevalence of PTSD among these Veterans was 30.9% for men and 26.9% for women" (Gradus 2014, p.1); this recent statistic reveals how absolutely necessary it is to have communication strategies available for an easier, healthier, and safer transition back into society for soldiers. Similar research has been completed with people that have traumatic brain injuries and strokes, but not for PTSD communication partners. Therefore, there is a need for this type of study.

Chapter 3: Methodology

This study was conducted using the qualitative research method of one-to-one interviews with four wives of service veterans who were identified as having PTSD. The interviews were conducted at locations chosen by participants in a Midwest city. Access to wives of veterans was gained through a support group for women married to veterans with PTSD. After initial contact with the first respondent, snowball sampling expanded the participant pool to the four participants included in the study. Due to the make-up of the support group, all of the women were married to Vietnam Veterans. Participation in this study was open to spouses of veterans from all war periods; however, spouses of more recently deployed veterans either reported that the veteran did not have the PTSD diagnosis or chose not to participate. Transcription data from the interviews were organized using an axial coding system (Bogdan & Biklen, 1992). As Bogdan and Biklin (1992) described, coding involved organizing data and then separating it into units, synthesizing it, searching for trends, considering what was important, and deciding how to create narratives that accurately portray the stories of the participants. This study is phenomenological in nature, attempting to understand the participant's perspectives via interviews (Bogdan & Biklen, 1992).

Open-ended, semi-structured, 60-minute interviews were conducted with volunteers until data saturation was reached. The interviews were audio-recorded, with permission from the participant. This method was chosen so that the principle investigator was able to make observations as well as gather descriptions of participants from a flexible conversation. Participants were asked approximately four questions, more or less, depending if their answers evolved to the goal of the study. The following questions were used in this study:

- How is your communication different now with the communication impairment involved compared to before?
- What event(s) led to your husband's language condition?
- What was he diagnosed with, in regard to language? What change did you see in him/her that was specific to language?
- How has his language condition impacted functioning at home?

Each participant was a wife and communication partner of a veteran. All of the participants were eighteen and over. No specifications or eliminations were used in choosing participants. Recruitment for this study occurred through colleagues with ties to veterans.

Chapter 4: Presentation of Data

Demographic information was obtained based on participants' responses to a demographic questionnaire. There were four participants in this study. The ages of the participants ranged from 64–66 years old. All participants were female. The husbands were 68–70 years old. Two of the four participants met their husband prior to military service. All four of the participants have children, all born after their husband's service. The lengths of service ranged from 10 months to two years, with all having served in Vietnam. Three of the four veterans served as infantry and one was a technician. Each couple attended a local Vietnam Veteran center that supports the full range of issues unique to the Vietnam war, creating a new identity for a new generation of veterans and changing public perception of Vietnam veterans.

Jen lives with her husband, Dan, who served in Vietnam and was diagnosed with PTSD before this study, in 2012. Jen and Dan met after his service. They have a daughter that lives nearby and has a very close relationship with them both. When Jen described the first 30 years of their marriage, she said "…we talked, but I never knew what was going on with him." They currently are receiving PTSD counseling through a Vet Center, treatment that has improved their relationship.

Rachel lives with her husband, Jackson, who also served in the Vietnam War, where he acquired severe hearing loss and PTSD. Rachel met Jackson after his service; they have two sons and a daughter together. She stated that they have a great connection, sharing the same sense of humor and that people enjoy being around them; however, they experience a lot of times that are not so fun. Jackson was diagnosed with PTSD two years ago, the same time that he had onset symptoms of Parkinson's disease, rapidly changing their typical communication styles in

addition to the PTSD issues. They have attended counseling sessions and found them to be helpful, but they are still figuring out how to handle Jackson's new symptoms and navigating the services that are available to him.

Margaret was married to Syd, her first husband, for 35 years. He passed away from lung cancer that was the result of his exposure to Agent Orange during his service in the Vietnam War. Margaret is an advocate and founding member at her local Vet Center. She met her second husband Davis, who is also a Vietnam veteran, through her work with veterans and spouses.

Finally, Crystal lives with her husband, Chuck, who served in the Vietnam war; he sustained a concussion and ear drum damage when a tank he was riding hit a land mine that exploded during his service. She and Chuck were high school sweethearts, so during her interview, Crystal reflected on their relationship before, during, and after Chuck's service in the war. She spoke of their correspondence via mail during the war and her superstitions that he would be discharged from the Army that eventually came true. She and Chuck have a grown son and daughter that each has their own families. Crystal and Chuck both have used counseling in the past to address Chuck's PTSD and as a way to improve their communication.

Analysis of participant interviews revealed several themes in the data. Though the focus of this research is on the communicative themes, a non-communicative theme emerged that was linked to a common process experienced by the participants. It is helpful to understand this non-communicative theme in order to understand the lived experiences of the participants and the impact of PTSD on their communication partners.

Non-communicative Theme: Perceived Unawareness

"When he came back from Vietnam, I knew he was a different person. I didn't know why, I thought, he was just different."—Margaret

All four participants described decades of time following their husbands' Vietnam service when neither they nor their husbands had awareness of PTSD symptoms.

Margaret met her first husband, Syd, prior to his service. They were married, and she was pregnant when he received his draft papers, originally deferring him, but when Margaret had a miscarriage, he was sent draft papers for a second time and ended up serving two years in Vietnam. When he returned, Margaret knew he was a different person. At the time she did not know what was different. Over the duration of their marriage, Margaret observed the following symptoms: alcoholism, road rage, hypervigilance, night terrors, and violent outbursts. Until he received a diagnosis of PTSD, which occurred around the 34th year of their marriage, she was unable to understand that the symptoms were the result of his service in the Vietnam War.

Syd maintained a job with a large company following his service up until they shut down. As a result, Syd began to exhibit aggression and an increased desire for isolation. He eventually found a building maintenance position that fit his needs. One day on the job, Syd's employer called Margaret because he would not get off the roof of a building. It was in the direct flight line of helicopters and Syd's body froze with fear. Margaret resorted to taking him to a VAMC inpatient center based on his repetition of the word "helicopters." The Vietnam War was the only connection she could make since he was not usually around helicopters. She had no idea until that point that his behaviors were directly related to his service.

Crystal also knew her husband, Chuck, before his deployment in Vietnam. She credits the life-long commitment they made to each other before he left for her commitment to help him

through PTSD symptoms; she attributes their long-standing marriage to the maintenance of this attitude. Regardless of their history, her affect was distant during the interview, as if she lived her life supporting yet isolated from Chuck. When Crystal spoke about Chuck's communication, she gave examples of peculiar behavior related to his PTSD, but added sentiment that she was okay with it. For instance, she thought that his desire to work on medical disaster teams was a strange and traumatic way to deal with his problems, but she supported him. In another example, she said that he was a workaholic, so she stayed home with the kids and "that was okay." She mentioned nonchalantly that he drank, but "not as much as some." Though her attitude was more supportive than the other women interviewed, Crystal was experiencing similar feelings of uncertainty about her husband's behavior.

Crystal described a breaking point for Chuck. He came back from disaster relief in Louisiana following Hurricane Katrina "broken." She watched him become angry, snapping at her during casual conversations. She did not know what was happening, so she would stay silent until the moment passed. He lost patience at work one day and almost hit a woman that he suspected to be lying about drug use. Crystal knew something was wrong, and Chuck did too. He researched the symptoms of PTSD and decided to seek out help. He attended a VA hospital out of state where Crystal conveyed that he gained perspective.

Jen met Dan after his service. She described the guilt she felt not knowing that Dan was suffering during the "lost years." She noticed that he was not emotionally on the same page with her when conversations became heated. Dan hit walls, became verbally aggressive, or the opposite, completely avoidant. He would sleepwalk and hide under the bed if he heard a siren. One night Jen woke up with her husband's hands around her neck and he was choking her. She

did not know what to do or say in that moment, she stayed silent until getting the courage to yell "You're not in the war anymore!"

Jen's reactions to Dan became more violent, and she had hit a breaking point. She wanted to leave him, but she loved him. She added, "I knew he loved me. That was never the problem." She asked herself how she would survive without him; she felt completely dependent on a person that was out of control. They had a daughter together, so she stayed. She forced herself to stop thinking about how her life could be different.

Rachel's experience is similar to Jen's. She observed her husband, Jackson's, unexplained behavior early on in their relationship, and it became the norm over the years due to a lack of education and awareness. Rachel said, "I was getting mad at him because I didn't understand." Rachel thought Jackson's fight or flight responses were untreatable, which created a barrier for their communication. She observed that these behaviors transpired when a plan did not run smoothly, which was frequent while their children were growing up. He would want to leave the situation or argue and get angry. Concerned about her husband, Rachel investigated the effects of serving in the Vietnam War at the library. She found that the VAMC would see Jackson and provide him with help. When presented with this idea, Jackson refused because he was not seeing his behavior as a problem, presenting another symptom of PTSD: denial.

The events leading up to, during, and immediately following the diagnosis of PTSD for the four participants were unique; however, they shared the theme that the process increased stress in their relationship. The wives highlighted roadblocks and revelations with their involvement in the diagnostic experience. In every case, a change, whether it was a lost job or negative behavior, occurred that spurred a desire for the couples to seek out a diagnosis and services.

Communicative Themes

This section explores participant perceptions of communication styles and characteristics. First, the wives described their husband's and their own manner of communicating prior to PTSD counseling; themes that emerged included *Avoidant Communication Style* and *Submissive Communication Style*. Then, through various means of talk therapy, the couples finally developed strategies to improve their relationships and address their needs, including the following theme: *Participation in Treatment*. Exclusive to each of their situations, this active step towards healing led to the women finding their voices.

Communicative Theme: Avoidant Communication Style

"He stuffed his problems."—Margaret

Margaret endured decades of Syd "stuffing his problems," a saying utilized by each of the participants to describe the avoidance and denial of sharing the traumatic experiences endured by their husband's during the war. Syd did not talk about the war to anyone, except occasionally mentioning that it had rained a lot in Vietnam and that he "had fallen in a bamboo pit once." Additionally, Margaret explained that Syd was unable to sustain his concentration long enough to tell what was bothering him, making communication extremely difficult. His impulsiveness was often in conjunction with pent-up aggression, paranoia, and jealousy. Margaret saw that when these characteristics emerged for Syd, he made poor communicative decisions. For example, if he heard fireworks going off late in his neighborhood, his impulse was to use physical and verbal violence to handle the situation rather than reasoning with the neighbor. Impulsiveness also shaped the type of job that was suitable for Syd. Margaret thought one job that he had working as a security guard at a high school fit his communication style

because it was acceptable to speak confrontationally with the students. He ended up changing jobs to a more isolated occupation when speaking that much became too overwhelming.

Similar to Syd, Jen's husband Dan rarely talked about Vietnam, or anything related to his emotions according to Jen. At a breaking point, Jen asked her sister-in-law if his communication was always this guarded. Dan's sister said that he was much more "aloof" following the war and that he did not speak to the family either. During most of their marriage, Jen and Dan did not communicate very well. It was frustrating to speak to him; their conversations were dominated by his intimidating nonverbal behavior and often limited to yes or no questions. She said, "generally, he had to be right": it was fight or flight.

Recently, Dan has shared with Jen that the hours he spent away from their family working 12-hour shifts were completely voluntary. Though Jen was very hurt by this confession, she has realized that this was his way of coping with his pain. "He didn't have to worry about talking to me or other people," explained Jen. They didn't need to yell or scream if they were not seeing each other, which made life a little easier for Jen, too. In this example, Dan's avoidance of communication confirmed and furthered Jen's beliefs that she had missed or ignored the signs that she was isolated from her husband.

Rachel felt that Jackson's communication was greatly impacted by PTSD. "He [didn't] know how to communicate," she said. PTSD was not actually affecting his speech, but it made communication difficult for them. She states that they have always had a hard time communicating. When describing his communication she said, "his brain, it just doesn't work right, you know?" In conversation, Jackson's responses were often confusing for Rachel. He gave tangential information that did not answer the question or his replies consisted of multiple answers. When she confronted him about his answer(s), he had to stop to think before

responding with his final answer. Jackson was aware that he misinterpreted information and then, in response, had outbursts of anger. Rachel felt that Jackson often preconceived what she would say and was on guard before she could get a word out.

Jackson did not communicate effectively with his children when they were younger. Rachel feels that the children not conforming to his set ways of thinking exacerbated his agitation. She described her youngest child, her daughter, as a "bold little soul" when she reflected on the characteristics that have helped her daughter nurture a healthy relationship with her father. Rachel also realizes that Jackson was not concerned about their daughter being drafted, like he was the boys. Additionally, anger became less of an issue as Jackson aged, so she was exposed to a different version of Jackson than the boys. Comparing herself with her daughter, Rachel felt that Jackson did not accept her boldness because she was his wife.

Recently, Jackson began to show deficits in thought processes, speech, and mobility. Rachel felt guilty for not knowing that Jackson was showing signs of Parkinson's disease. Since the symptoms occurred in conjunction with the Comprehensive Hearing held by the VAMC that determined Jackson's PTSD diagnosis, Rachel grew frustrated and overwhelmed. She was mistaking the "wide-eyed masked face" of a person with the onset of Parkinson's and progressive hearing loss for her husband's ineffective communication due to PTSD. She thought he was using a "shaky" voice for attention, trying to get her to feel sorry for him. Reflecting on her attitude towards the PTSD symptoms that he has had for the duration of their relationship, "I thought he was just being difficult."

Communicative Theme: Submissive Communication Style

"They thought I was a doormat."—Rachel

Rachel recalled that the women she met through the Vet Center brought attention to her submissive communication. In Rachel's initial meetings with the group, members described her as a "doormat." Rachel laughed about this label during the interview because she felt it was given to her from a loving place, a place of familiarity for the other women. It was in response to Jackson's on guard behavior that Rachel resorted to a submissive form of communication. She needed a life with less conflict, so she did not participate in conversations with him. She viewed Jackson's "blowups" as him not taking time to actively listen to her. His responses did not match her intentions. She gradually quit communicating with him.

Similarly, Jen walked on eggshells around Dan. She was intimidated by his reactions to her speaking, so she fell silent. This happened over many years of dysfunction and conflict. She would end up giving in to his verbal and nonverbal aggression because she feared his response, which commonly was a look that conveyed for her to "just drop it." All she could do was observe and tread lightly. She felt that their communication was empty and unproductive, leaving her in a constant state of not knowing.

Margaret shares a story similar to Jen and Rachel, spending the first decades of her marriage using passive language with Syd. She overlooked red flags and conflicts, stating that there "wasn't much communication happening" and that she was used to it. She survived by being easy to get along with and minimally vocalizing her opinions. Her communication matched her actions; she stepped lightly, "on eggshells" around Syd. She felt that until she met people that had experienced similar situations, she was misunderstood.

Unlike the other spouses, Crystal did not describe her own communication style as passive, but rather exclusively referred to a specific time period when she noticed increased silence between her and Chuck. Following Chuck's breakdown around the time of Hurricane Katrina, Crystal recalled bouts of silence they had related to Chuck's anger. She chose to be mostly silent and explained that "you can't talk to somebody when they are angry and snappy." In describing this time, she used the pronouns "we" rather than "I," reflective of an attitude neither taking nor giving blame for the silence.

Communication Strategy: Participation in Treatment

Playing an active role in treatment became a focus for each participant once they were aware of their husbands' diagnosis of PTSD. Each had a unique, gradual process since many years of conditioned responses dictated how the wives' reacted to PTSD-related behaviors. Spousal participation in treatment increased opportunities for healthy conversations and resulted in an improved understanding of how PTSD impacted their relationship.

The first time Rachel's husband, Jackson, considered PTSD treatment, it was while having dinner with another couple where the husband was a veteran. Rachel noticed how safe Jackson felt expressing his ignorance and fears associated with seeking out help in the company of another veteran and the veteran's wife. He said that he desperately feared that the Army would send him back to war, a detail he had never shared with her. Together, Rachel and Jackson decided to take the advice of the couple to see a counselor at the Vet Center that was trained in treating veterans with PTSD.

As a result of the counseling, Rachel saw Jackson calm down, relax, and open up to support from fellow veterans. They were informed that he would have to go to a comprehensive

examination required by the VAMC to receive all of his benefits. Once Jackson was notified of the exam, his nervousness built up; Rachel said, "…it opened so many wounds" but he went through with it so that he could get help. The day of his VAMC comprehensive exam, he was a nervous wreck, fearful that he might fail the test. Rachel sensed that during his isolated interview he had to tell the psychiatrist about events in Vietnam that he had not shared with her or the other veterans yet. For her portion of the interview, Jackson was present. She was told to just talk about her life with him, consequently bringing up the emotions that she usually withheld. Following the interview, Jackson validated Rachel's feelings by telling her that he was amazed at how "the things [she] said were almost verbatim of what he said about [their] life." Participating in this examination deepened Rachel's insight to Jackson's triggers. He fell into a depression after the exam, creating a barrier to his progress at the Vet center. Rachel knew the cause of the depression was related to opening up, so she was able to empathize and care for Jackson with the support of her new community of veteran families.

Similarly, Margaret attended the VAMC comprehensive exam with her husband, Syd. She reported that the psychiatrist told her to sit in the hall during his portion, but she refused, claiming that she had been married to him for 35 years and that she knew he would not be able to sustain his attention long enough to express his concerns. They let her go in, to her surprise; she found out information related to Syd's diagnosis of PTSD, benefits, and supportive services that she was convinced that he would not have conveyed to her if he had been alone in the interview. She realized from this experience the importance of her role as an advocate for Syd due to his attentional lapses.

Jen's husband, Dan, went to the VAMC comprehensive examination alone. She said that he wanted her to go with him, but she refused. Jen's attitude was "this is not my mess," claiming

that she "didn't want to know what was going on." She remembers him coming home from the appointment and said to her, "I have PTSD." Due to the resentment she felt toward the years he had spent with the symptoms, she maintained the attitude that PTSD was his problem. She did not go with him to the VAMC for follow-up appointments because she did not want to know the truth or take any ownership over it. Consequently, Jen's refusal to participate resulted in communication that continued to suffer and missed opportunities to support her husband's healing process as well as her own.

Now that Jen is active in Dan's treatment, she has been more vigilant and applied strategies to help him avoid triggers. She looks for clues, for instance if he has had a few nights in a row of nightmares she then thinks back to what event or trigger may have set him off. She explained that her awareness has helped their communication because she can help him avoid situations that might trigger the behaviors that used to generate conflicts in their relationship.

Crystal's husband, Chuck, went to the Vet Center for individual counseling and Crystal attended a Women's group simultaneously. They both gained perspective to the broad spectrum of suffering soldiers. Participating in treatment provided validation for Crystal that their problems are less severe compared to other veteran couples. She rationalized some of Chuck's behaviors: he was not doing drugs and he was not *that* angry; however, she did start to see subtle behaviors as problems between them. Originally, they were under the assumption that he had to have the extreme symptoms, drug and alcohol abuse that were typically associated with PTSD. She shared a story explaining one of Chuck's triggers:

> He would go out and be near the villagers and protect them and to make sure when they brought their rice in, they would get their proper rice back, where the
> Viet Cong did not do that. If they brought the rice in, and it was like 10 pounds, they

might only be able to get a pound back. Because the Marine Corps were giving them what they put in, they began to trust them and so they had a good rapport with them. They were doing really well. My husband got to know a family with a young daughter, and he always liked to make the kids giggle and laugh and play with them when they were going through the village, and they went out on patrol one time and they came back and the Viet Cong had come in and killed the majority of the villagers, but they had killed the family and the little girl and that is one of his traumas is seeing the little girl. My son was in the Marine Corps also and he married a young lady from Japan, and they have two little girls and it was always difficult for him (husband) to see the girls because then he would have nightmares about the other little girl. But now that the girls are older, that is not a problem anymore.

Crystal now has an understanding attitude that this is one of his triggers. Participating in counseling on this topic allowed her to understand how PTSD played a role in damaging a relationship. Crystal found that she had deeper insight of PTSD with her growing understanding of combat and warfare. She also empathizes with the relationship strain that occurs when soldiers come back from deployment and find that their families have adjusted to life without them. Partners have to be strong and take over the roles that the soldiers once had. And then when they come back, the role is different, and they all have to adjust again. She empathizes with his triggers when she thinks about how he witnessed his friends dying and that it affects him daily.

New Communication Patterns

"Speak to him what is on my heart."—Rachel

Each participant experienced communication changes with their spouse from the time they started treatment through a local Vet Center to the time of the interviews. Treatment varied for each couple; however, services available included readjustment counseling, individual, group, marital, bereavement, sexual trauma, and family counseling (Toledo Vietnam Vets, 2015).

Rachel and Jackson have experienced positive changes in communication, even in the face of adversity. Jackson's depressive state following his comprehensive exam did not keep him from communicating with Rachel; however, the rapid decline caused by Parkinson's Disease made the act of speaking much more difficult.

Following his diagnosis Rachel saw a quick decline in the effectiveness of her communication with Jackson. He began isolating himself again and having negative self-talk, saying in response to certain situations "I am just stupid." She is not sure whether this was due to the onset of Parkinson's or if it was his depression. His walking and talking progressively got worse. According to Rachel, Jackson "has very bad speech and listening skills now." He stumbles over his words and shows signs of dysfluency when his speech comes to a halt, and he begins gasping while trying to get words out as fast as possible.

Although Rachel has learned about PTSD, she still feels herself struggling to bring Jackson "down to a level where he can talk sensibly" with her. Her attempts have changed, in that she chooses to "share what is on her heart" and it has occasionally changed his responses from the usual on guard demeanor to a softer, gentler discussion together. She describes him as having a "softened heart." Conflict still occurs, but they have taken a different form. Jackson

uses the nonverbal sign of covering his ears to show Rachel that he does not want to hear what she has to say, and Rachel is able to remind herself that, "it is not personal, it is something he is dealing with." Now that Rachel has found her voice in their relationship, she finds herself speaking without thinking, having the opposite effect of her submissive communication style. She exclaimed, "When you can finally speak up, you take advantage of it!"

Looking back, Jen knows that she would have approached her communication with Dan differently had she known about PTSD. She would have had him talk more; ask him to share his experiences the way she does now. She would have protected him from triggers, but in reality, it was not an option before since he was not telling her why he was reacting. Jen said that following counseling he started to share with her and others in the family stories that feel like puzzle pieces of their past. Though he did not explicitly explain what was going through his mind, she started to pick up on triggering stimuli. Inconsistent with her past support toward Dan, when he began to speak about something personal, Jen checked on him to see if he was okay and assured him that she was not ashamed of his actions. She started waking him up in the middle of the night to check on him during or after nightmares. She said, "There [were] certain things that [triggered] him. I [was] aware." She felt a sense of pride behind her support, knowing that he was such a survivor. She recalled a triggering moment for Dan:

> Notices were being nailed to trees of an upcoming event. They reminded Dan of the notices posted prior to Agent Orange being sprayed on a lake near him while he was in Vietnam. He dissociated, was unable to remove himself from the terrifying thoughts that were associated with Agent Orange.

He was able to explain after he felt grounded to Jen and his daughter what caused him to dissociate. Dan has learned that it is possible to feel safe sharing his stories with others. Another

example, he chose to share a book of memories with a family member and Jen's first thought was, "it took him 30 years to show me that." She found herself taking a step back to appreciate that he is now able to open up himself that way. She decided that supporting him goes further than holding on to the resentment she feels. It helped learning from other wives of veterans and counselors as to why he took so long to ask for help.

Though it takes her out of her comfort zone, Jen says "If he wants to talk about [the war], I listen." She has learned to put a positive spin on the often heavy, traumatic stories Dan shares with her. He is able to look at his experiences differently when he hears her perspective. Additionally, Dan began to understand the way that his actions affected Jen. When Dan gave Jen "the look," she held him accountable and he has the chance to change his communication approach with her. This new way of communicating has changed their marriage and Jen's attitude toward her husband's experiences at war. She has decided that "PTSD is our problem" and that "It is totally amazing what [Dan] has gone through and what kind of man he is today."

Margaret found her voice as well over the years and noticed a change in her communication with Syd. Their communication was more effective when they were attending the Vet Center together, experiencing their own healing, yet receiving consistent education. Margaret took on a mentorship role, advising younger spouses of their rights and the services that helped her. Though she didn't have much time with Syd to repair their relationship, she has taken a new approach with her second husband, speaking her mind and making efforts to keep communication open.

Chapter 5: Data Analysis

The themes from this study were divided into two categories: non-communicative and communicative. This distinction enabled analysis to occur based on direct PTSD communication issues versus co-occurring symptoms that were identified and unidentified obstacles to progress toward effective communication.

Non-communicative Theme: Perceived Unawareness

Not understanding the symptomology of PTSD was a theme described by the participants in this study. According Woods (2010), spouses of active soldiers found that not knowing how to help their soldier with PTSD symptoms made them feel useless. The participants in discussing the support received from the military conveyed anger. For some of the participants, anger was directed at the husband. Woods also found that some spouses, due to lack of education, believed that PTSD was the soldier's fault for enlisting themselves into the military (2010).

Similar to Woods' findings, the participants in this study described their experiences and the impact of not having adequate education concerning PTSD. Some of the wives structured their lives around their husband's PTSD symptoms for survival. Since the husbands were not sharing the emotions or stories around the traumas, the wives were not able to fully understand the effect of the trauma and therefore misunderstood or underestimated the impact of their service on daily life. Some participants compared their husband's symptoms to extreme/stereotypical cases of PTSD or thought the symptoms were related to normal aging and decided that they were not showing severe enough signs to seek help. Then a severe situation occurred, causing them to finally seek out help. Some participants were convinced that the

symptoms they observed were irreversible and therefore untreatable. Finally, the denial of PTSD for all of the participants and their husbands caused them to reflect on their lack of education on PTSD and second-guess that there was a problem at all.

Cognitive processes can be compromised following TBI, creating a disposition to PTSD that makes it difficult for the brain to process PTSD symptoms, which provides a possible explanation for the extended delayed expression experienced by veterans (Elder & Christian, 2009). The result of the delayed expression is isolation, similar to descriptions provided by the participants in this study and supported by research; this creates a challenging environment for developing trust with spouses and family members that want to support the veteran (Francis, 2010). The VAMC has started to require TBI screenings for all OIF and OEF veterans due to the change of warfare in recent conflicts (Dennis, 2009).

One participant was explicit that her husband had sustained brain injury during their service, while the others described cognitive-communication symptoms that align with TBI, but confirmed they had never received diagnosis or rehabilitative services. Examples of cognitive-communication impairment symptoms described by participants in this study included inability to sustain attention long enough to tell what was bothering the veteran; impulsivity in conjunction with aggression, paranoia, and jealousy; poor communicative decisions; shallow awareness and reasoning; confusing responses; and misinterpreting questions.

This data reveals a non-communicative theme that indirectly connects to the way couples communicate. Not understanding or being unaware of symptoms or the onset of PTSD can lead to conditioned, long-standing miscommunication. This finding reveals the significance of comprehensive PTSD education for former and currently active military families.

Communicative Theme: Avoidant Communication Style

The avoidant communication style of veterans with PTSD described by the participants in this study is consistent with symptomology of PTSD. A study that surveyed 47 midwestern Vietnam Veterans found that high levels of intrusive thoughts and avoidance symptoms in participants with PTSD have been associated with lower levels of interconnection, expressiveness, and marital satisfaction (Hendrix, Jurich, & Schumm, 1995). Along the same lines, Renaud (2008) found that out of the 49 male veterans with combat-related PTSD, most endorsed insecure attachment styles, which were related to attachment avoidance. The veterans that endorsed attachment styles characterized by high avoidance (fearful and dismissing) had higher PTSD symptoms than those with lower avoidance; therefore, it was found that both attachment anxiety and avoidance were found to contribute to the severity of PTSD symptoms (Renaud, 2008).

Renaud (2008) also found that chronic states of alarm, a common symptom of PTSD, might interfere with engaging other people in effective, emotionally regulating exchanges. This may be expressed as pushing others away through harmful emotional manifestations (anger, fear, lack of emotional reciprocity) or pulling away from others in order to decrease triggering stimuli. This reaction changes emotional connectedness into an unrewarding experience, in turn deactivating the attachment system (Milkulincer, Shaver, & Pereg, 2003). Approaches for communication partners to address avoidant communication are not evident in the literature.

Participants in this study described their husband's communication as avoidant, intimidating, and a challenge for them to understand. Some described the struggle they had understanding their husband's avoidance since they were not sharing anything about their traumatic event to anyone. Some described their husbands as guarded, always in flight or flight

mode. And finally, as a common way of coping with their intrusive thoughts, some of the husbands chose to work excessive hours, completely avoiding interactions with their spouse. The theme of avoidant communication style in veterans with PTSD found in this study is affirmed by literature; however, there is still a need for evidence-based strategies that spouses can use to improve conversation reciprocity.

Communicative Theme: Submissive Communication Style

The participants in this study described a change in their communication after years of living with their husbands. Most described themselves as submissive. Dekel, Goldblatt, Keidar, Solomon, and Polliack (2005) found that wives of Israeli veterans with PTSD lived in fear due to their husbands' suicidal tendencies. In order to calm their fears, they immersed themselves into their spouse's daily rituals resulting in a role change from wife to caregiver. Marital boundaries then became enmeshed and individuality diminished. One wife described the ambiguity of her husband's presence as living with a "dead person" (Dekel et al., 2005, p.30).

In response to husband's guarded communication styles, all of the participants in this study developed submissive communication styles in order to avoid conflict and survive day to day. When they would try to be more assertive, the husband's reactions often did not match their intentions, therefore creating friction. Minimally vocalizing opinions became the norm for most of the participants, until they eventually pursued couples counseling.

Related to the submissive communication style among participants, their attitude toward their marriage and the overall well being of their partner influenced their communication style. As stated before, PTSD symptoms are negatively related to virtually all areas of marital functioning for both husbands and wives (Allen, Rhoades, Stanley, & Markman, 2010).

Participants in a similar study noted at different stages of their recovery, the importance of their commitment to their husband which included: confidence that the marriage can survive long term, their dedication to each other and the marriage, and their satisfaction with sacrifice (Allen, Rhoades, Stanley, & Markman, 2010). Woods (2010) found that uncertainty about marriage was common among younger couples with one person being a veteran with PTSD, while a sense of duty was common among the older participants in the theme of decisions.

Most participants in this study, before receiving counseling, placed blame on their veteran spouses by not involving themselves in the journey of PTSD. Following counseling, most of the participants had changed their attitudes to reflect a connectedness with their husband to show that they supported them and were going through the healing process together. Some of the participants discussed their commitment to their marriage as the reason for staying with their husband regardless of the severity of their PTSD, others discussed their dependency on the marriage as a means for living. Having an attitude that reflects joint ownership over PTSD seemed to enhance effective communication as well as overall support during treatment.

Communication Strategy: Participation in Treatment

Having communication partners participate in treatment was both supported by all of the participants in this study as well as the following literature. One study focused on the supports offered to caregivers of patients with TBI, which concluded that a partner's understanding of potential supports for conversational communicative behaviors appears to affect his or her aptitude to support that individual with communicative dysfunction (Bowen et al., 2001). Hoepner's study (2010) with communication partners of patients with TBI found that partner's attitudes affect their ability to act as effective supports and that without training on how to speak

to patients with TBI, most non-injured partners required training on how to make conversational repairs.

New Communication Patterns: "Speak to him what is on my heart."—Rachel

Research was unavailable on cognitive basis of communication with PTSD for men, women, or veterans. Evidence of PTSD communication training was not found to this date either; however, "Emotional Regulation Training" is a technique being used to treat post-TBI, cognitive-communication deficits that restrict and decrease the effectiveness of cognitive functions. These deficits result in procrastination or impulsivity (Gordon, Cantor, Ashman & Brown, 2006). Emotional Regulation Training follows three steps:

1. Observation of experiences (behaviors, emotions, thoughts, and physiological) that occur in response to conflict and the ways in which they hinder problem solving;

2. Analysis of precursors (contexts, triggers, and warning signs of maladaptive emotional responses to problem situations); and

3. Reframing and planning, including recognition of illogical, maladaptive, and inaccurate thoughts and the use of positive self-talk, and use of behavioral techniques such as relaxation breathing.

Similar to the steps of Emotional Regulation Therapy, each participant in this study spent years prior to PTSD diagnosis (a) observing their husband's experiences (fight or flight, isolation, impulsivity), then once given diagnosis, (b) analyzed precursors (triggers: locations, events, communication), and finally based on observations and precursors had the foundation to (c) reframe and plan to improve the communication with their partners. This link supports the

need for spouses to be involved in treatment as well as the need for research that addresses overlap of TBI and PTSD in the scope of cognitive-communication disorders.

According to the participants in this study, it is vital to understand the complexity of the combat exposure veterans experienced, not only to understand the husband's behaviors, but also, to understand their reactions. This finding aligns with Bjornstead's (2009) results that found the severity of post-traumatic symptoms in the soldier predicts the severity of secondary traumatic stress symptoms in the spouse.

Some of the participants in this study spoke about how the changes they observed in their own communication reflected the confrontation and violent style of their husbands. Following treatment, most of the participants found that initiating conversations about PTSD symptoms and asking questions about traumatic experiences deepened their awareness of PTSD triggers, resulted in their own decline in PTSD symptoms. This finding is a strategy to improve communication and when connected to the literature, can be used to predict severity of PTSD symptoms.

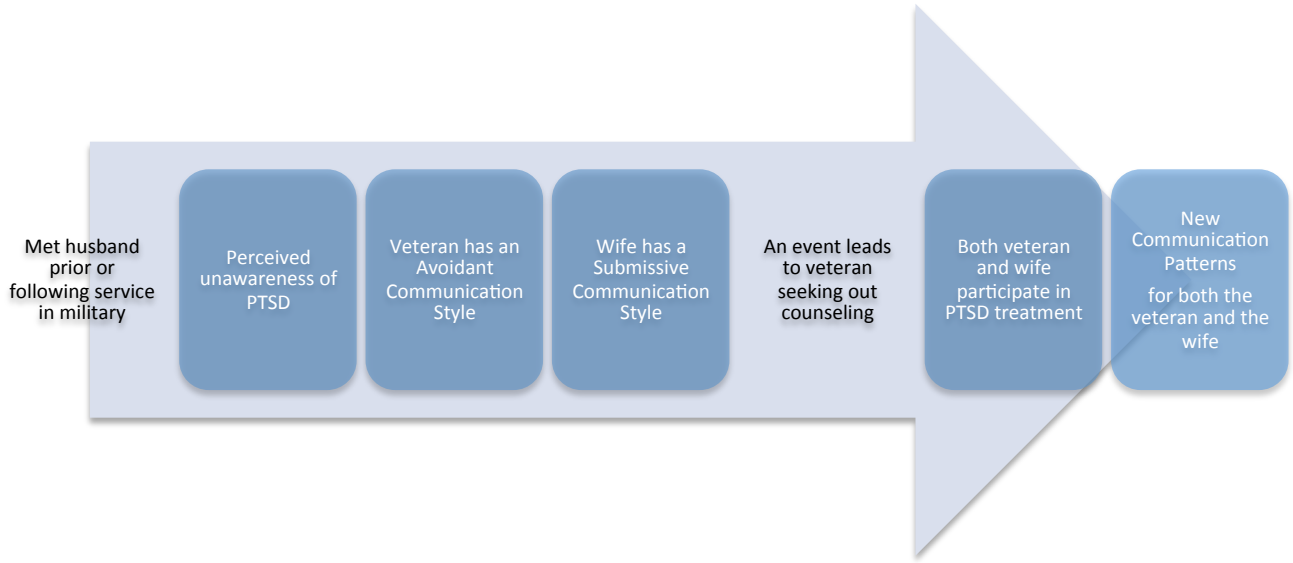
Chapter 6: Conclusions

Summary of Results

This study provides insights to communication provided by wives of Vietnam War veterans with PTSD. A non-communicative theme and several communicative themes were found in this study including:

- perceived unawareness of PTSD
- the veteran's avoidant communication style
- the wife's submissive communication style
- joint participation in treatment for PTSD
- new communication patterns as a result of treatment

The following pattern was found amongst each participant's journey living with a veteran that had PTSD.



Perceived unawareness of PTSD was a non-communicative theme that impacted the lives of each participant. Feelings associated with not understanding PTSD symptomology included uselessness, anger, and resentment. The couples' conversations were restricted in content, resulting in limited trust. The delayed expression of PTSD symptoms common among the wives' husbands led to years of isolation in their relationships as well as conditioned, long-standing periods of miscommunication.

An avoidant communication style was the theme found for veteran communication prior to PTSD treatment. This common symptom of PTSD was found to result in low levels of interconnection, expressiveness, and marital satisfaction for the participants. The chronic state of fear that accompanied avoidant communication added an additional layer of interference during engagement and conversational reciprocity. Avoidant communication style was expressed by the husbands in this study as anger, guardedness, fight or flight reaction, and working long hours at their job.

A submissive communication style was the theme found for spouse communication prior to their husbands receiving PTSD treatment. The wives lived in fear, consequently structuring their lives around their husband's unpredictable behaviors. They became caregivers, eventually losing their sense of individuality. Any form of assertion displayed by the wife was silenced by the avoidant behaviors of the husband. Conversational reciprocity was indirectly affected by the wives' negative attitudes toward their marriage and outlook of partner's overall health.

Breaking points (i.e., unemployment, overexposure to triggers) led the veterans to seek out PTSD treatment. The theme of participation in treatment was found to increase the participant's aptitude for supporting their husband's communicative dysfunctions. Participation for the wives increased understanding of PTSD symptoms, introduced them to a community of

military families, and improved the consistency of accuracy in information being received by the veteran for services. Participation in treatment led to the final theme of new communication patterns. The PTSD journey described by participants was compared to Emotional Regulation Training, used for TBI patients. The observation, then analysis of triggers the veterans were experiencing led the wives to reframe their communication to meet the needs of the veteran. A comprehensive understanding of the combat exposure their husbands endured was found to improve communication because they knew the source of irrational reactions. Initiating conversations and asking more questions related to PTSD symptoms led to decreased submission by the wives.

Potential Clinical Implications

Delayed responses to PTSD reported by participants are a sign that their husband's were never diagnosed as having brain injuries from their service. This lapse of time between trauma and emerging symptoms could be decreased potentially if TBI screenings were a requirement for not only OIF/OEF soldiers, but also soldiers from earlier conflicts. Having a TBI diagnosis could lead to finding cognitive-communication deficits that could then be treated, resulting in improved communication due to implemented compensatory strategies. Improved communication strategies could decrease the delayed expression of PTSD symptoms, and in return decrease the longevity of symptoms that negatively impact relationships. The new TBI screening requirements overlook service people prior to OIF/OEF; therefore, there is a population of people being diagnosed and treated for PTSD symptoms through various Vet Centers and outpatient clinics that are not receiving cognitive treatment to address possible TBI.

Cognitive-communication services provided by SLPs have been included in the interdisciplinary approach to treating veterans with TBI; however, there is a large population of veterans receiving PTSD diagnosis without TBI that are struggling to communicate with their spouses. Applying successful cognitive-communication approaches to PTSD populations could reveal an area of SLP that is relatively untapped due to the lack of current successful models to treat veterans. Additionally, spouses are experiencing vicarious trauma that act as a barrier to effective communication with their spouses. This study reveals an increased need for couple's speech therapy, or increased participation of spouses in speech therapy settings, given its success in other counseling settings. Spouses that have taken on the caregiver role for their spouse have sacrificed individuality that impacts communication, therefore should be nourished and focused on in therapy.

Long term communication patterns emerged due to the extensive length of marriages each participant had. The rising rates of recent veterans and divorce could be related to the limited, short term communication that the couples have endured together. Conversely, newer veterans have more immediate services available to them that focus on communication, therefore, the negative impact of PTSD on communication could be less severe compared to Vietnam era couples. Spousal participation in PTSD treatment led to increased insight during conflicts for the participants in this study. Enriched opportunities for healthy communication, models of healthy communication, and in return, decreased instances of communication breakdown/message breakdowns occurred as well. All of the participants discussed positive changes in attitude toward their husband as a result of communication strategies and PTSD education. Hoepner (2010) highlighted the use of a tool, partner support behavior profiles (PSBP), as a measure of partners of patients with TBI behaviors, which included the following:

1. Categorization of partner behaviors into subtypes (specific antecedent behaviors);
2. Identification of negative behaviors that revealed partner weaknesses (and underlying attitudes);
3. Inclusion of measures of perceived success, enjoyment, and burden of interactants;
4. A coding scheme related to clinical impressions; and
5. High inter-rater reliability.

Application of PSBP to a population of communication partners of veterans from each war period could shed light on the characteristics that would improve communication between military couples.

Limitations/Delimitations of the Study

This study focused on the experiences of a small group of Vietnam veteran wives from a small geographical area, limiting its relevance to a small population of veteran spouses. Exploring the experiences of a more diverse pool of participants (i.e., sex, ethnicity, race, location, and extent of service, more recent service) would provide support and additional factors to consider when approaching treatment of communication with veterans that have PTSD and their spouses.

Directions for Future Study

Analysis of interviews with the four participants in this study led to the identification of several factors related to their communicative interactions with their veteran husbands that were living with PTSD. Comparison of these results with research from the field of speech-language

pathology and psychology, social work, and counseling implies that the current treatment models would benefit from a more interdisciplinary approach.

In order for SLPs to create the safe environment necessary for veterans to communicate about daily living tasks, an interdisciplinary approach is imperative; first by involving mental health support to address the trauma-related symptoms and collaborate with the SLP to identify triggers that could be avoided during cognitive-communication therapy. Then the SLP could discuss communicative strategies: potential conversation starters, safe alternatives for triggering environments, personal boundaries, problem solving, reasoning, and decision-making. This could provide a deepened understanding of PTSD triggers for the spouse as well as decreased severity of symptoms of PTSD for the veteran. Additionally, communication between the SLP and mental health support regarding the phase of CBCT, or related therapy program, a patient and their spouse have reached could improve treatment outcomes for cognitive-communication therapy (Blount et al., 2014). Further research in this area is necessary for improving current evidence-based techniques available to SLP's.

Though veterans with PTSD are a heterogeneous population, finding commonalities between the influences of different wars could be beneficial for the current population of veteran families suffering due to avoidant communications styles. Using Hoepner and Turkstra's (2009) PSBP tool, or a more compatible tool with PTSD communication partners could be valuable for future implications in the field of speech-language pathology.

References

Allen, E. S., Rhoades, G. K., Stanley, S. M., & Markman, H. J. (2010). Hitting home: Relationships between recent deployment, posttraumatic stress symptoms, and marital functioning for Army couples. *Journal of Family Psychology*, *24*(3), 280.

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders*, (5th ed.). Washington, DC: Author.

Beck, L., Cornis-Pop, M., (2011). VA Polytrauma System of Care: Cross-Disciplinary Mandates and Exemplars. *ASHA Convention 2011*. Lecture conducted from San Diego, CA.

Biddle, D., Elliott, P., Creamer, M., Forbes, D., & Devilly, G. J. (2002). Self-reported problems: A comparison between PTSD-diagnosed veterans, their spouses, and clinicians. *Behaviour research and therapy*, *40*(7), 853-865.

Bjornestead, A. G. (2009). *Secondary traumatic stress symptoms in military spouses of army national guard veterans* (Order No. AAI3382619). Available from PsycINFO. (622327646; 2010-99071-121).

Blount, T., Fredman, S. J., Pukay-Martin, N. D., Macdonald, A., & Monson, C. M. (2014). Cognitive-Behavioral Conjoint Therapy for PTSD: Application to an Operation Enduring Freedom Veteran. *Cognitive and Behavioral Practice*.

Bogdan, R., & Biklen, S. (1992). Qualitative research for education: An introduction to theory and methods (2nd ed.). Boston: Allyn and Bacon.

Bowen, A., Tennant, A., Neumann, V., & Chamberlain, M. A. (2001). Neuropsychological rehabilitation for traumatic brain injury: Do carers benefit? *Brain Injury*, *15*(1), 29-38.

Carter, S., Loew, B., Allen, E., Stanley, S., Rhoades, G., & Markman, H. (2011). Relationships between soldiers' PTSD symptoms and spousal communication during deployment. *Journal of Traumatic Stress*, *24*(3), 352-355.

Dekel, R., Goldblatt, H., Keidar, M., Solomon, Z., & Polliack, M. (2005). Being a Wife of a Veteran with Posttraumatic Stress Disorder*. *Family Relations*, *54*(1), 24-36.

Dennis, K. C. (2009). Current perspectives on traumatic brain injury. *ASHA Access Audiology*, *8*(4).

Elder, G. A., & Cristian, A. (2009). Blast-related mild traumatic brain injury: Mechanisms of injury and impact on clinical care. *Mount Sinai Journal of Medicine: A Journal of Translational and Personalized Medicine*, *76*(2), 111-118.

Francis, P. C. (2010). *Veterans and mental health: Support and serving the emotional needs of student veterans.* Webinar for Paperclip Communications, Little Falls, NJ.

Friedman, M. (2014). *PTSD History and Overview*. US Department of Veteran Affairs. Retrieved from http://www.ptsd.va.gov/professional/PTSD-overview/ptsd-overview.asp.

Gordon, W. A., Cantor, J., Ashman, T., & Brown, M. (2006). Treatment of post-TBI executive dysfunction: Application of theory to clinical practice. *The Journal of Head Trauma Rehabilitation*, *21*(2), 156-167.

Gradus, J. (2014). Epidemiology of PTSD. *PTSD: The National Center for PTSD.* Retrieved from http://www.ptsd.va.gov/professional/PTSD-overview/epidemiological-facts-ptsd.asp

Hendrix, C. C., Jurich, A. P., & Schumm, W. R. (1995). Long-term impact of Vietnam war service on family environment and satisfaction. *Families in Society*, *76*(8), 498.

Hoepner, J. K. (2010). *Characteristics of Effective Communicative Partners in Supporting Persons with Traumatic Brain Injury* (Doctoral dissertation, University of Wisconsin--Madison).

Hoepner, J. K., & Turkstra, L. S. (2009). Video-based administration of the La Trobe Communication Questionnaire for adults with traumatic brain injury and their communication partners. *Brain injury*, *27*(4), 464-472.

Johnson, S., Sherman, M, Hoffman, J. et al (2007). *The psychological needs of US military service members and their families: A preliminary report*. Washington, DC: American Psychological Association.

Okie, S. (2005). Traumatic brain injury in the war zone. *New England Journal of Medicine*, *352*(20), 2043-2047.

Renaud, E. F. (2008). The attachment characteristics of combat veterans with PTSD. *Traumatology*, *14*(3), 1.

Schneider, S. L., Haack, L., Owens, J., Herrington, D. P., & Zelek, A. (2009). An interdisciplinary treatment approach for soldiers with TBI/PTSD: Issues and outcomes. *SIG 2 Perspectives on Neurophysiology and Neurogenic Speech and Language Disorders*, *19*(2), 36-46.

Toledo Vietnam Vets (2015). Vietnam Veterans of Greater Toledo Ohio: The official site for V.V.A. Chapter 35. Retrieved from http://www.toledovietnamvets.com/Toledo_Vet_Center.html.

VA National Center for PTSD (2009). Returning from the War Zone; A Guide for Families of Military Members. Retrieved July 8, 2015 from http://www.ptsd.va.gov/public/reintegration/guide-pdf/FamilyGuide.pdf

Woods, J. N. (2010). *When a soldier returns home from Iraq and/or Afghanistan with post-traumatic stress disorder: The lived experience of the spouse* (Doctoral dissertation, CAPELLA UNIVERSITY).

APPENDIX A: Human Subjects Approval Letter

Date: Sat Aug 16 2014
Subject: MS #1246 - College of Education Human Subjects Review
From: Beth Kubitskey
Decision: Accept Submission

Dear MARDEE A. Kohlmann, Congratulations! After careful review, your proposal "Communication Characteristics of Effective Communicative Partners for Veterans with Post-traumatic Stress Disorder (PTSD)" has been accepted by the College of Education Human Subjects Review committee. We stress that you do not stray from your proposed plan. Good luck with your research effort. The current version of your submission is available here: http://commons.emich.edu/cgi/preview.cgi?article=1246&context=coehs You may also view the reviews and preview your submission on that page. To submit revisions, use the Revise Submission link on that page.